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	175517	A. BUILDING _____ B. WING _____	C 08/11/2015

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
BROOKDALE OVERLAND PARK	**12000 LAMAR OVERLAND PARK, KS 66209**

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 000	INITIAL COMMENTS The following citations represent the findings of complaint investigation #88518, 86958, 88591, & 89641.	F 000		
F 309 SS=E	483.25 PROVIDE CARE/SERVICES FOR HIGHEST WELL BEING Each resident must receive and the facility must provide the necessary care and services to attain or maintain the highest practicable physical, mental, and psychosocial well-being, in accordance with the comprehensive assessment and plan of care. This Requirement is not met as evidenced by: The facility census totaled 83 resident with 9 residents sampled. Based on observation, record review, and interviews, the facility failed to provide pain management for 4 (#2, #4, #5, and #7) of 4 residents sampled for pain management. Findings included: - Resident #2's Medicare 5 day assessment dated 5/9/15 documented the resident with Brief Interview for Mental Status (BIMS) score 14 documented the resident was cognitively intact. The assessment further documented the resident on pain management with scheduled pain medications, as needed medications, and on non-medication interventions. The resident reported a pain intensity of 8 on a scale of 0-10 (with 0 as no pain and 10 as the worst pain). The initial pain care plan dated 5/5/15 included the following interventions: to administer analgesia (pain medications) as per the physician's orders, give the pain medication half	F 309		

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE | TITLE | (X6) DATE

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an hour before a treatment or care as needed, encourage the resident to report any pain, monitor/record the pain characteristics: quality (for example: sharp, burning); severity (0 to 10 scale, 0 no pain and 10 worst pain); anatomical location; onset; duration (for example: continuous, intermittent); aggravating factors; and relieving factors, observe and report changes in usual routine, sleep patterns, decrease in functional abilities, and decrease in range of motion (ROM), withdrawal or resistance to care, provide the resident and family with information about pain and options available for pain management, and discuss and record the resident's preferences.

The clinical record documented the resident was admitted to the facility on 5/5/15 following a left knee replacement and history of chronic pain.

The clinical record documented on 5/6/15 the resident's pain level was 9.

The clinical record documented on 5/7/15 and 5/8/15 the resident's pain level was 8.

The Physician Ordered Sheet (POS) dated 5/4/15 documented the resident received the following pain medications: Oxycontin (narcotic) 20 milligrams (mg) every 12 hours for 7 days, Mobic (anti-inflammatory) 15 mg daily for 30 days, Gabapentin (used for postoperative pain) 1200 mg three times a day, Morphine sulfate (narcotic) 15 mg - 30 mg every 3 hours as needed, and Tylenol 325 mg - 650 mg every 4 hours as needed.

The controlled substance proof of sign our sheet documented the resident received Oxycontin CR (controlled release narcotic) 20 mg scheduled

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and was given on 5/5 at 7:30 P.M., on 5/6/15 at 7:00 A.M. and 7:00 P.M., on 5/8/15 at 7:00 A.M. and 7:00 P.M., and on 5/9/15 at 7:15 A.M.

The controlled substances proof of use sign out sheet documented the resident received Morphine Sulfa IR (immediate release narcotic) 15 mg 1-2 tablets every 3 hours as needed (on 5/5/15 at 7:30 P.M.; on 5/6/15 at 12:30 A.M., 3:30 A.M., 9:00 A.M., 12:10 P.M., 5:00 P.M., and 11:30 P.M.; on 5/7/15 at 4:15 A.M., 7:00 A.M., 12:30 P.M., 5:00 P.M., and 10:45 P.M.; and on 5/8/15 at 5:30 A.M., 8:30 A.M., 1:00 P.M., and 5:00 P.M.

The clinical record lacked documentation related to this resident's level of pain and the effectiveness after the resident received the pain medications.

An interview on 8/5/15 at 12:15 P.M. with direct care staff O stated if a resident complained of pain then he/she would tell the charge nurse.

An interview on 8/5/15 at 4:10 P.M. with direct care staff P stated he/she would report to the charge nurse when a resident complained of pain.

An interview on 8/5/15 at 4:20 P.M. with licensed nursing staff J stated if a resident had pain, then would need to assess what kind of pain, rate the pain from 0-10, give the resident medication and follow up to see if the pain medication relieved the pain.

An interview on 8/6/15 at 9:15 A.M. with licensed nursing staff K stated when the facility was using paper medication sheet; the nurses had to initial the medications that were given. When a resident complained of pain, the nurses would have to

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write on the pain medication flow sheet the date, the time, location of the pain, the pain level, the mediation given, and the follow up on the resident's pain level.

The 7/2015 revised facility policy "Pain Management" instructed the nursing staff to identify the level of pain, document as indicated, and include the effectiveness.

The facility failed to ensure the nursing staff adequately assessed the resident's pain level, monitor the resident's pain level, and follow up with this resident related to his/her pain management.

- Resident #4's Medicare 5 day assessment dated 6/28/15 documented the resident's cognitive status was not assessed. The Minimum Data Set assessment (MDS) documented the resident was on pain management with as needed pain medication.

The initial pain care plan dated 6/29/15 included the following interventions: to administer analgesia (pain medications) as per the physician's orders, give the pain medication half an hour before a treatment or care as needed, encourage the resident to report any pain, monitor/record the pain characteristics: quality (for example: sharp, burning); severity (0 to 10 scale, 0 no pain to 10 the worst pain); anatomical location; onset; duration (for example: continuous, intermittent); aggravating factors; and relieving factors, observe and report changes in usual routine, sleep patterns, decrease in functional abilities, and decrease in range of motion (ROM), withdrawal or resistance to care, provide the resident and family with information about pain and options available for pain

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management, and discuss and record the resident ' s preferences.

The clinical record documented the resident was admitted to the facility on 6/23/15 following a left arm fracture.

The clinical record documented the resident received Naproxen (analgesic), Norco (narcotic pain medication, and Tylenol (analgesic) during a 4 day time period.

The clinical record lacked documentation to the resident's level of pain and the effectiveness after the resident received the pain medications.

An interview on 8/5/15 at 12:15 P.M. with direct care staff O stated if a resident complained of pain then he/she would tell the charge nurse.

An interview on 8/5/15 at 4:10 P.M. with direct care staff P stated he/she would report to the charge nurse when a resident complained of pain.

An interview on 8/5/15 at 4:20 P.M. with licensed nursing staff J stated if a resident had pain, then would need to assess what kind of pain, rate the pain from 0-10, give the resident medication and follow up to see if the pain medication relieved the pain.

An interview on 8/6/15 at 9:15 A.M. with licensed nursing staff K stated when the facility was using paper medication sheet; the nurses had to initial the medications that were given. When a resident complained of pain, the nurses would have to write on the pain medication flow sheet the date, the time, location of the pain, the pain level, the mediation given, and the follow up on the resident

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F 309	Continued From page 5 ' s pain level. The 7/2015 revised facility policy "Pain Management" instructed the nursing staff to identify the level of pain, document as indicated, and include the effectiveness. The facility failed to ensure the nursing staff adequately assessed the resident's pain level, monitor the resident's pain level, and follow up with this resident related to his/her pain management. - Resident #5 was admitted on 7/28/15 with the diagnosis of Cerebrovascular accident (CVA) (stroke) - the sudden death of brain cells due to lack of oxygen caused by the impaired blood flow to the brain by blockage or rupture of an artery to the brain. The initial care plan related to the resident's stroke dated 7/29/15 included the following interventions: give medications as ordered, monitor/document for side effects and effectiveness, pain management as needed, and provide alternative comfort measures. The clinical record documented the resident's pain level on 7/30/15 was rated at 8 (scale of 0-no pain to 10 the worst pain), on 7/31/15 was rated at 3 different times at 6, 7, and 6, and on 8/2/15 was rated at 3 times at 3, 3, and 5. The medication administration record documented the resident received Tylenol (analgesic) twice a day with a pain level of 3 to 5. The clinical record lacked documentation to the effectiveness after the resident received the pain	F 309		

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medications.

An interview on 8/5/15 at 12:15 P.M. with direct care staff O stated if a resident complained of pain then he/she would tell the charge nurse.

An interview on 8/5/15 at 4:10 P.M. with direct care staff P stated he/she would report to the charge nurse when a resident complained of pain.

An interview on 8/5/15 at 4:20 P.M. with licensed nursing staff J stated if a resident had pain, then would need to assess what kind of pain, rate the pain from 0-10, give the resident medication and follow up to see if the pain medication relieved the pain.

An interview on 8/6/15 at 9:15 A.M. with licensed nursing staff K stated when the facility was using paper medication sheet; the nurses had to initial the medications that were given. When a resident complained of pain, the nurses would have to write on the pain medication flow sheet the date, the time, location of the pain, the pain level, the mediation given, and the follow up on the resident's pain level.

The 7/2015 revised facility policy "Pain Management" instructed the nursing staff to identify the level of pain, document as indicated, and include the effectiveness.

The facility failed to ensure the nursing staff adequately assessed the resident's pain level, monitor the resident's pain level, and follow up with this resident related to his/her pain management.

- Resident #7 was admitted on 8/3/15 with a

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F 309	Continued From page 7 fractured (a broken bone) right arm and left leg. The initial pain care plan dated 8/4/15 included the following interventions: encourage the resident to try different relieving methods like positioning, relaxation therapy, progressive relaxation, bathing, heat and cold applications, muscle stimulation, and/or ultra-sound; to administer analgesia (pain medications) as per the physician's orders, give the pain medication half an hour before a treatment or care as needed, encourage the resident to report any pain, monitor/record the pain characteristics: quality (for example: sharp, burning); severity (0 to 10 scale, 0 no pain to 10 the worst pain); anatomical location; onset; duration (for example: continuous, intermittent); aggravating factors; and relieving factors, observe and report changes in usual routine, sleep patterns, decrease in functional abilities, and decrease in range of motion (ROM), withdrawal or resistance to care, and provide the resident and family with information about pain and options available for pain management. The Medication Administration Record (MAR) documented the resident received Norco (narcotic pain medication) on 8/4/15 at 8:55 A.M. and 8:18 P.M., on 8/5/15 at 8:31 A.M. and 8/6/15 at 8:45 A.M. The clinical record lacked documentation related to this resident's level of pain and the effectiveness after the resident received the pain medications. An interview on 8/5/15 at 12:15 P.M. with direct care staff O stated if a resident complained of pain then he/she would tell the charge nurse.	F 309		

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F 309	Continued From page 8 An interview on 8/5/15 at 4:10 P.M. with direct care staff P stated he/she would report to the charge nurse when a resident complained of pain. An interview on 8/5/15 at 4:20 P.M. with licensed nursing staff J stated if a resident had pain, then would need to assess what kind of pain, rate the pain from 0-10, give the resident medication and follow up to see if the pain medication relieved the pain. An interview on 8/6/15 at 9:15 A.M. with licensed nursing staff K stated when the facility was using paper medication sheet; the nurses had to initial the medications that were given. When a resident complained of pain, the nurses would have to write on the pain medication flow sheet the date, the time, location of the pain, the pain level, the mediation given, and the follow up on the resident's pain level. The 7/2015 revised facility policy "Pain Management" instructed the nursing staff to identify the level of pain, document as indicated, and include the effectiveness. The facility failed to ensure the nursing staff adequately assessed the resident's pain level, monitor the resident's pain level, and follow up with this resident related to his/her pain management.	F 309		
F 328 SS=D	483.25(k) TREATMENT/CARE FOR SPECIAL NEEDS The facility must ensure that residents receive proper treatment and care for the following special services: Injections; Parenteral and enteral fluids;	F 328		

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F 328	Continued From page 9 Colostomy, ureterostomy, or ileostomy care; Tracheostomy care; Tracheal suctioning; Respiratory care; Foot care; and Prostheses. This Requirement is not met as evidenced by: The facility census totaled 83 residents with 9 sampled. Based on observation, record review, and interviews, the facility failed to monitor store the oxygen equipment when not in use for 2 of 3 (#8 and #9) sampled with oxygen use. Findings included: - Resident #8's admission Minimum Data Set assessment (MDS) dated 6/20/15 documented the Brief Interview for Mental Status (BIMS) score 13 which documented the resident was cognitively intact. The MDS documented the resident required extensive assistance of 2 staff members with bed mobility, transfers, dressing, and toilet use, and extensive assistance of 1 staff member with personal hygiene. The MDS further documented the resident required oxygen therapy. The activities of daily living Care Area Assessment (CAA) dated 6/30/15 documented the resident had recently been hospitalized for pneumonia (inflammation of the lungs) and needs assistance with activities of daily living due to weakness. The initial care dated 6/18/15 documented the resident had impaired airway clearance related to chronic obstructive pulmonary disease (progressive and irreversible condition	F 328		

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characterized by diminished lung capacity and difficulty or discomfort in breathing) and pneumonia. The interventions included to auscultate lung sounds as needed, report any abnormalities to the physician, oxygen saturation as ordered, breathing treatments as ordered, assess respiratory status: rate, depth, pattern and peripheral skin color, and report abnormalities to the physician.

Review of the clinical record documented the resident's oxygen saturations checked every shift and ranged from 91 per cent (%) to 98%. The clinical record documented the staff to apply oxygen at night at 2 liters per a nasal cannula.

On 8/5/15 at 7:35 A.M. the resident observed in the bathroom and the oxygen concentrator turned on with the oxygen tubing lying across the resident's bed.

On 8/5/15 at 10:30 A.M. the therapy staff observed applying legs dressings to the resident, oxygen tubing lying on the floor next to the oxygen concentrator.

Interview with licensed nursing staff H on 8/5/15 at 11:55 A.M. stated the nurses were responsible to make sure the oxygen tubing was placed in the bags on the concentrator and/or the portable tank when not in use. The direct care staff could also make sure the tubing was put away when not in use.

Interview with licensed nursing staff I on 8/5/15 at 12:05 P.M. stated the oxygen tube should be placed in the mesh bag.

Interview with direct care staff O on 8/5/15 at 12:15 P.M. stated the oxygen tubing should be

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placed in the mesh bag that was placed on the concentrator or the tanks when not in use.

Interview with administrative nursing staff D on 8/5/15 at 2:25 P.M. stated the oxygen tubing should be placed in the mesh bags on the concentrator or portable tanks.

Interview with licensed nursing staff J on 8/5/15 at 4:20 P.M. stated RN the oxygen tubing should be placed in the mesh bag when not in use.

Interview with direct care staff P on 8/5/15 at 5:30 P.M. stated the oxygen tubing should be placed in the mesh bag on the concentrator or the portable tank.

The 7/2015 facility policy "Oxygen Management" instructed the nursing staff to store the cannula and/or mask in a plastic bag when not in use.

The facility failed to ensure the nursing followed the facility's guidelines for the safe storage of the oxygen equipment for this resident when not in use.

- Resident #9's admission Minimum Data Set assessment (MDS) dated 7/31/15 documented the Brief Interview for Mental Status (BIMS) score 12 which documented the resident with moderate cognitive impairment. The MDS documented the resident required limited assistance of 1 staff member with bed mobility, transfers, dressing, toilet use, and personal hygiene. The MDS further documented the resident required oxygen therapy.

The activity of daily living Care Area Assessment (CAA) dated 8/5/15 documented the resident was weak related to pneumonia (inflammation of the

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lungs).

The initial care plan dated 7/31/15 documented the resident had altered respiratory status/difficulty breathing related to pneumonia. The interventions included to provide oxygen as ordered.

The clinical record documented on 8/6/15 at 1:11 P.M. documented the resident continued with oxygen at 4 liters without difficulty.

The resident observed on 8/5/15 at 10:55 A.M. in bed with oxygen delivered at 4 liters from the oxygen concentrator. A portable oxygen tank was seen in the resident's room with oxygen tubing wrapped around handle.

The resident observed on 8/6/15 at 1:30 P.M. sleeping with oxygen provided from the concentrator. The portable oxygen tank observed with tubing wrapped around the handle.

Interview with licensed nursing staff H on 8/5/15 at 11:55 A.M. stated the nurses were responsible to make sure the oxygen tubing was placed in the bags on the concentrator and/or the portable tank when not in use. The direct care staff could also make sure the tubing was put away when not in use.

Interview with licensed nursing staff I on 8/5/15 at 12:05 P.M. stated the oxygen tube should be placed in the mesh bag.

Interview with direct care staff O on 8/5/15 at 12:15 P.M. stated the oxygen tubing should be placed in the mesh bag that was placed on the concentrator or the tanks when not in use.

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F 328	Continued From page 13 Interview with administrative nursing staff D on 8/5/15 at 2:25 P.M. stated the oxygen tubing should be placed in the mesh bags on the concentrator or portable tanks. Interview with licensed nursing staff J on 8/5/15 at 4:20 P.M. stated RN the oxygen tubing should be placed in the mesh bag when not in use. Interview with direct care staff P on 8/5/15 at 5:30 P.M. stated the oxygen tubing should be placed in the mesh bag on the concentrator or the portable tank. The 7/2015 facility policy "Oxygen Management" instructed the nursing staff to store the cannula and/or mask in a plastic bag when not in use. The facility failed to ensure the nursing followed the facility's guidelines for the safe storage of the oxygen equipment for this resident when not in use.	F 328		
F 353 SS=E	483.30(a) SUFFICIENT 24-HR NURSING STAFF PER CARE PLANS The facility must have sufficient nursing staff to provide nursing and related services to attain or maintain the highest practicable physical, mental, and psychosocial well-being of each resident, as determined by resident assessments and individual plans of care. The facility must provide services by sufficient numbers of each of the following types of personnel on a 24-hour basis to provide nursing care to all residents in accordance with resident care plans: Except when waived under paragraph (c) of this section, licensed nurses and other nursing	F 353		

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personnel.

Except when waived under paragraph (c) of this section, the facility must designate a licensed nurse to serve as a charge nurse on each tour of duty.

This Requirement is not met as evidenced by:
The facility census totaled 83 resident with 9 residents sampled. Based on observation, record review, and interviews, the facility failed to provide nursing staff to provide nursing services to attain or maintain the highest practicable physical, mental, and psychosocial well-being for 4 residents (#2, #4, #5, and #9) of the 9 residents sampled.

Findings included:

- Resident #2's Medicare 5 day assessment dated 5/9/15 documented the resident with Brief Interview for Mental Status (BIMS) score 14 documented the resident was cognitively intact. The Minimum Data Set assessment documented the resident required limited assistance with dressing and required supervision of 1 staff member with bed mobility, transfers, toilet use and personal hygiene.

Review of the facility's call light record from 5/5/15 until 5/9/15 for this resident documented the resident had to wait from 1 minute (the shortest wait time) to 25 minutes (the longest wait time) for someone to answer his/her call light.

Review of resident council minutes for 9/24/14, 10/29/14, 1/28/15, 2/25/15, 6/24/15, and 7/22/15 documented the call lights were slow to be answered.

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F 353	Continued From page 15 Interview on 8/5/15 at 11:15 A.M. with administrative nursing staff D stated when a call light was turned on, the signal immediately goes to the direct care staff's pager that was taking care of that resident, after 3 minutes the signal goes to all the direct care staff on the unit, after another 3 minutes the signal goes to the charge nurse, after another 3 minutes the signal goes to the unit manager, after another 3 minutes the signal goes to the assistant director of nursing, and after another 3 minutes the signal goes to the executive director. When the signal goes through the list of receivers, the signal would recycle and start over. Interview on 8/5/15 at 11:55 A.M. with licensed nursing staff H stated when a resident turned on the call light, the signal would immediately go to the direct care staff assigned to them and then at 3 minute intervals to other staff members until the call light was answered. Interview on 8/5/15 at 12:15 P.M. with direct care staff O stated he/she normally tries to answer the call lights as soon as page comes across the pager. Direct care staff O stated his/her pager was broke and the facility did not have another one that he/she could use. Direct care staff O stated he/she was checking more frequently on the residents assigned to him/her and the other direct care staff would tell him/her if one of his/her residents turned on their call lights. Interview on 8/5/15 at 4:10 P.M. with direct care staff P stated the call lights go to the pagers. He/she stated the signal first goes to the direct care staff taking care of that resident and if the call light was not answered by 3 minutes the signal would go to the other direct care staff on	F 353		

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the unit, and after another 3 minutes the signal goes to the charge nurse.

Interview on 8/5/15 at 4:20 P.M. with licensed nursing staff J stated the call light signals starts with going immediately to the direct care staff taking care of the resident, then to all the direct care staff after 3 minutes, and then to the charge nurse after an additional 3 minutes.

The revised October 2010 facility policy "Answering the Call Light" documented the purpose of the call lights was to respond to the resident's requests and needs. The policy directed the staff to answer the resident's call as soon as possible.

The facility failed to ensure the nursing staff answered this dependent resident's call lights in a timely manner.

- Resident #4's Medicare 5 day assessment dated 6/28/15 documented the resident required extensive assistance of 2 staff members with bed mobility, transfers, dressing, and toilet use.

Review of the facility's call light record from 6/23/15 to 6/27/15 for this resident documented the resident had to wait from less than 1 minute (shortest wait time) to 35 minutes (the longest wait time) for someone to answer his/her call light.

Review of resident council minutes for 9/24/14, 10/29/14, 1/28/15, 2/25/15, 6/24/15, and 7/22/15 documented the call lights were slow to be answered.

Interview on 8/5/15 at 11:15 A.M. with administrative nursing staff D stated when a call

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light was turned on, the signal immediately goes to the direct care staff's pager that was taking care of that resident, after 3 minutes the signal goes to all the direct care staff on the unit, after another 3 minutes the signal goes to the charge nurse, after another 3 minutes the signal goes to the unit manager, after another 3 minutes the signal goes to the assistant director of nursing, and after another 3 minutes the signal goes to the executive director. When the signal goes through the list of receivers, the signal would recycle and start over.

Interview on 8/5/15 at 11:55 A.M. with licensed nursing staff H stated when a resident turned on the call light, the signal would immediately go to the direct care staff assigned to them and then at 3 minute intervals to other staff members until the call light was answered.

Interview on 8/5/15 at 12:15 P.M. with direct care staff O stated he/she normally tries to answer the call lights as soon as page comes across the pager. Direct care staff O stated his/her pager was broke and the facility did not have another one that he/she could use. Direct care staff O stated he/she was checking more frequently on the residents assigned to him/her and the other direct care staff would tell him/her if one of his/her residents turned on their call lights.

Interview on 8/5/15 at 4:10 P.M. with direct care staff P stated the call lights go to the pagers. He/she stated the signal first goes to the direct care staff taking care of that resident and if the call light was not answered by 3 minutes the signal would go to the other direct care staff on the unit, and after another 3 minutes the signal goes to the charge nurse.

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Interview on 8/5/15 at 4:20 P.M. with licensed nursing staff J stated the call light signals starts with going immediately to the direct care staff taking care of the resident, then to all the direct care staff after 3 minutes, and then to the charge nurse after an additional 3 minutes.

The revised October 2010 facility policy "Answering the Call Light" documented the purpose of the call lights was to respond to the resident's requests and needs. The policy directed the staff to answer the resident's call as soon as possible.

The facility failed to ensure the nursing staff answered this dependent resident's call lights in a timely manner.

- Resident #7 was admitted on 8/3/15 with a fractured (broken bone) of his/her right arm and left leg.

On 8/5/15 at 2:00 P.M. observed the resident in his/her room, sat in a wheelchair with a cast on his/her right arm and his/her right leg with an immobilizer (equipment to prevent the resident form moving their leg). The resident stated he/she needed help with getting in and out of his/her wheelchair and to go to the bathroom. The resident stated the direct care staff who was taking care of him/her early in the day did not have a pager, so he/she was checking on him/her to see if anything was needed.

Review of the facility's call light record for 8/5/15 documented this resident had to wait from 1 minute (the shortest wait time) to 35 minutes (the longest wait time) for someone to answer his/her call light.

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F 353	Continued From page 19 Review of resident council minutes for 9/24/14, 10/29/14, 1/28/15, 2/25/15, 6/24/15, and 7/22/15 documented the call lights were slow to be answered. Interview on 8/5/15 at 11:15 A.M. with administrative nursing staff D stated when a call light was turned on, the signal immediately goes to the direct care staff's pager that was taking care of that resident, after 3 minutes the signal goes to all the direct care staff on the unit, after another 3 minutes the signal goes to the charge nurse, after another 3 minutes the signal goes to the unit manager, after another 3 minutes the signal goes to the assistant director of nursing, and after another 3 minutes the signal goes to the executive director. When the signal goes through the list of receivers, the signal would recycle and start over. Interview on 8/5/15 at 11:55 A.M. with licensed nursing staff H stated when a resident turned on the call light, the signal would immediately go to the direct care staff assigned to them and then at 3 minute intervals to other staff members until the call light was answered. Interview on 8/5/15 at 12:15 P.M. with direct care staff O stated he/she normally tries to answer the call lights as soon as page comes across the pager. Direct care staff O stated his/her pager was broke and the facility did not have another one that he/she could use. Direct care staff O stated he/she was checking more frequently on the residents assigned to him/her and the other direct care staff would tell him/her if one of his/her residents turned on their call lights. Interview on 8/5/15 at 4:10 P.M. with direct care staff P stated the call lights go to the pagers.	F 353		

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He/she stated the signal first goes to the direct care staff taking care of that resident and if the call light was not answered by 3 minutes the signal would go to the other direct care staff on the unit, and after another 3 minutes the signal goes to the charge nurse.

Interview on 8/5/15 at 4:20 P.M. with licensed nursing staff J stated the call light signals starts with going immediately to the direct care staff taking care of the resident, then to all the direct care staff after 3 minutes, and then to the charge nurse after an additional 3 minutes.

The revised October 2010 facility policy "Answering the Call Light" documented the purpose of the call lights was to respond to the resident's requests and needs. The policy directed the staff to answer the resident's call as soon as possible.

The facility failed to ensure the nursing staff answered this dependent resident's call lights in a timely manner.

- Resident #9's admission Minimum Data Set assessment (MDS) dated 7/31/15 documented the resident with a Brief Interview for Mental Status (BIMS) score 12 which documented the resident with moderately impaired cognitive status. The MDS documented the resident required limited assistance of 1 staff member with bed mobility, transfers, dressing, toilet use, and personal hygiene.

Review of the facility's call light record from 7/26/15 until 8/1/15 for this resident documented the resident had to wait from 1 minute (the shortest wait time) to 93 minutes (the longest wait time) for someone to answer his/her call light.

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Review of resident council minutes for 9/24/14, 10/29/14, 1/28/15, 2/25/15, 6/24/15, and 7/22/15 documented the call lights were slow to be answered.

Interview on 8/5/15 at 11:15 A.M. with administrative nursing staff D stated when a call light was turned on, the signal immediately goes to the direct care staff's pager that was taking care of that resident, after 3 minutes the signal goes to all the direct care staff on the unit, after another 3 minutes the signal goes to the charge nurse, after another 3 minutes the signal goes to the unit manager, after another 3 minutes the signal goes to the assistant director of nursing, and after another 3 minutes the signal goes to the executive director. When the signal goes through the list of receivers, the signal would recycle and start over.

Interview on 8/5/15 at 11:55 A.M. with licensed nursing staff H stated when a resident turned on the call light, the signal would immediately go to the direct care staff assigned to them and then at 3 minute intervals to other staff members until the call light was answered.

Interview on 8/5/15 at 12:15 P.M. with direct care staff O stated he/she normally tries to answer the call lights as soon as page comes across the pager. Direct care staff O stated his/her pager was broke and the facility did not have another one that he/she could use. Direct care staff O stated he/she was checking more frequently on the residents assigned to him/her and the other direct care staff would tell him/her if one of his/her residents turned on their call lights.

Interview on 8/5/15 at 4:10 P.M. with direct care

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F 353	Continued From page 22 staff P stated the call lights go to the pagers. He/she stated the signal first goes to the direct care staff taking care of that resident and if the call light was not answered by 3 minutes the signal would go to the other direct care staff on the unit, and after another 3 minutes the signal goes to the charge nurse. Interview on 8/5/15 at 4:20 P.M. with licensed nursing staff J stated the call light signals starts with going immediately to the direct care staff taking care of the resident, then to all the direct care staff after 3 minutes, and then to the charge nurse after an additional 3 minutes. The revised October 2010 facility policy "Answering the Call Light" documented the purpose of the call lights was to respond to the resident's requests and needs. The policy directed the staff to answer the resident's call as soon as possible. The facility failed to ensure the nursing staff answered this dependent resident's call lights in a timely manner.	F 353		